

Zambia National Conference on Public/Private Sector Partnership for Health

Conference Proceedings
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Abbreviations and Acronyms

ADS	Acquired Immuno-deficiency Syndrome
CB	Community Based Distributor
CMAZ	Church Mission Association of Zambia
CS	Community Survey
CSO	Central Statistical Office
DALY	Disability Adjusted Years
DDM	Data for Decision Making Project
DHMB	District Health Management Board
DMCH	Deputy Minister of Health
GP	General practitioner
GRZ	Government of the Republic of Zambia
HHRAA	Health and Human Resources and Analysis for Africa
HIV	Human Immune Virus
Hon.	Honorable
HRT	Health Reform Implementation Team
MMD	Movement for Multiparty Democracy
MOD	Ministry of Cultural Development
MOF	Ministry of Finance
MCH	Ministry of Health
MP	Member of Parliament
MSL	Medical Stores Limited
NDP	National Drug Program
NGO	Nongovernmental organizations
PPA	Private Practitioners' Association
PS	Permanent Secretary
PS2	Priority Survey 2
PSI	Population Sciences International
THPAZ	Traditional Health Practitioners Association of Zambia
USAID	United States Agency For International Development

UTH	University Teaching Hospital
ZAMPI	Zambia Association of Manufacturing Pharmaceutical Industries
ZCCM	Zambia Consolidated Copper Mines
ZMA	Zambia Medical Association

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Executive Summary

In 1991 the GRZ embarked on a program of economic and political reforms. The reforms were needed to institutionalize greater participation in the political process, and to foster greater competition and efficiency in the economy. The MOH has been a leading agency in the conceptualization and implementation of reforms. Within the health sector the reforms include profound decentralization of authority and responsibility to districts and hospital boards, approaches to introduce efficiency in the allocation and use of resources, development of public/private sector partnership, and community participation in management and financing of services.

The architects of Zambia's health reforms recognized the actual and potential contributions of the private sector as early as 1991. In 1993 MOH and USAID collaborated on an assessment of nongovernmental health care provision in Zambia. The assessment was one of four country studies that were reviewed at a regional conference on the same subject financed by the Africa Bureau and held in Nairobi, Kenya, in December 1994. In early 1995 the MOH and USAID collaborated on preparation of the "Zambia Child Health Project". Public/private sector partnership is one of five principal outputs of this project. A national conference focusing on public/private partnership was identified as an urgent 'bridging activity'. The conference took place June 8-11, in Siavonga, Zambia, and was attended by about 60 participants representing relevant agencies of GRZ, the MOH, donors, and other key stakeholder groups. Rolf Sartorius of Team Technologies, Inc. acted as facilitator for the conference. Objectives of the conference were to provide a forum for the public and private sectors to communicate with each other, identify actual and potential areas of collaboration, identify constraints and solutions to private sector development, and recommend critical next steps.

At the opening ceremony the conference was addressed by the Permanent Secretary (PS) of the MOH, the Acting Director of USAID/Zambia, and the Senior Health Economics and Financing Advisor of the Health and Human Resources Analysis for Africa (HHRAA) project. The PS outlined the rationale for health reforms in general and public/private sector partnership in particular, listed the set of events leading up to the conference, indicated objectives of the conference, and urged participants to look for common goals and objectives of the two sectors in the interest of improving the health status of the Zambian population. The Acting Director of the USAID mission applauded the leadership of the

Ministry in the implementation of health reforms, reaffirmed his Agency's commitment to the sector, and expressed his hope that the conference would come up with recommendations and plan of action that would strengthen the partnership between the two sectors. The Advisor from the HHRAA project explained why the conference was necessary, the rationale for the issues emphasized in the agenda, identified some challenges to the health system, and urged participants to stay focused on the issues relevant to the objective of producing more and better health care.

The keynote speech was given by the Honorable Dr. Katele Kalumba, the Deputy Minister of Health. Dr. Kalumba outlined the history of health reforms and pointed out that the political environment for reform still remains turbulent. Part of the problem is caused by the lack of appreciation of technical problems by politicians, and political imperatives by technicians. The Deputy Minister emphasized that the reforms are intended to introduce efficiency in resource allocation, decentralize authority and responsibility, enhance community participation, and mobilize private sector resources both for financing and provision of services. Regarding public/private sector partnership, he pointed out that the interdependent yet adversarial relationship between the two sectors influences the allocation of scarce national resources. He indicated some of the areas in which the two sectors could collaborate, and characterized the building of beneficial and complementary links between the two sectors as the new frontier of health reforms.

Health Sector Reforms and the National Health Strategy

Mr. Vincent Musowe (Chief Planner, MOH) and Dr. Sam Nyaywa (Head of HRIT) presented the rationale, objectives, and principal elements of the health reform program. Dr. Nyaywa described the major health problems and identified the relative significance of each health problem by using disability adjusted life years (DALYs) as indicators. HIV/AIDS accounted for 76% of DALYs lost.

Mr. Musowe gave a brief description of the health care delivery system and listed the reforms that are now in place. They include reorganization of the central MOH, decentralization, increase in the allocation GRZ funds to MOH, reallocation of MOH budget in favor of districts and hospital boards, and cost sharing. Mr. Musowe pointed out that public/private sector partnership was an important element of the reforms and indicated areas (such as contracting, and franchising) where such partnership could be exercised.

Concepts and Issues in Public/Private Sector Partnership for Health

Dr. Bekele presented a short paper on this subject written with Dr. P. Berman of Harvard University. Definitions of public and private sector were given. The private sector constitutes all entities not directly under state control and management. The diversity of the private sector was illustrated by introducing three criteria: therapeutic form (traditional or modern), commercial orientation (for-profit or not-for-profit), and organizational complexity (ranges from single part-time operators to complex tertiary hospitals and HMOs).

Areas for public/private sector linkages were identified. They include in broad terms activities of the public sector (both in financing and provision) that would have impact on private sector behavior, taxes and subsidies, regulations, and contracting arrangements.

Interests and expectations of each sector were identified in general form and areas for possible collaboration were explored. Franchising and contracting were identified as promising areas for collaboration in the near to medium term.

Panel On Public/Private Sector Partnership

The panel consisted of five participants representing modern private practitioners, traditional medicine, church affiliated health institutions, manufacturers of pharmaceuticals, and the mines.

The following problems and constraints were identified by modern private practitioners:

- a. Inadequate managerial skills;
- b. Frequent and often frivolous litigation;
- c. Discriminatory taxation against private practice;
- d. Lack of legal recognition and traffic rights for privately owned ambulances; and
- e. Theft and robbery.

The representative of traditional health practitioners highlighted the significance of the sector, called for development of partnership based on mutual respect and trust, and identified the following problems:

- a. Failure of the GRZ to institutionalize and legitimize traditional practice;

- b. Lack of funding for research and development; and
- c. Lack of goodwill on the part of decision makers.

This panelist called for a dialogue and closer collaboration between the modern and traditional sectors, and asked for government assistance in standardizing traditional practice.

The representative of ZCCM elaborated on the scope of health services provided by his agency which included promotive, preventive, and curative services, as well as other health related services such as water supply and environmental health. The representative listed a number of opportunities for his agency to collaborate with the public as well as the non-governmental sectors. Opportunities include sharing of specialists, equipment, facilities, and training.

The panelist representing missions (CMAZ) gave a brief description of services provided by mission affiliated facilities and the significance of the sector. Mission affiliated facilities account for 30% of hospital beds in the country and about 40% of all outreach activities. The importance of these facilities is further amplified by the fact that 39 rural districts provide services ranging from promotive/preventive to curative and rehabilitative procedures. Constraints the sector faces include:

- a. Unstable sources of funding;
- b. Lack of clarity in the relationship with the MOH; and
- c. Inadequate staffing.

The panelist representing manufacturers pointed out that his young trade group has 25 members and intends to represent the interests of its membership to government, and ensure optimum quality standards. Problems faced by manufacturers include:

- a. Late payment of bills by the government; and
- b. Discriminatory taxes against domestic production.

Working Group Reports (Day One)

Three working groups to review the implications of the health reforms for various actors in Zambia were set up on the first day of the conference. The reports of the working groups are summarized below:

A. Health Sector Reforms and Their Implications for the Private Sector

1. Households will be required to provide some services at home and participate in cost sharing. This would empower them as well as give them greater choice of providers. Households may realize reduction in the cost of care due to greater competition.
2. The traditional sector will be forced to be more competitive since the reforms will encourage the development of modern practice.
3. The reforms will encourage the expansion of the community based distribution system.
4. The state should introduce guidelines and regulations for quality control and consumer protection.
5. The reforms will allow expansion of all elements of the private sector.

B. The Role of the Private Sector in the Reforms

1. The private sector will expand and there will be greater competition.
2. MOH/GRZ should facilitate private sector development and participation by:
 - a. Updating restrictive regulations on the private sector;
 - b. Improve and institutionalize communication between the public and private sectors;
 - c. MOH should contract out services;
 - d. MOH should encourage local production of pharmaceutical and medical supplies;
 - e. Control waste and inefficiency in the procurement and distribution of drugs; and
 - f. MOH should constitute a task force to oversee the development of public/private sector partnership.

C. Consumers and the Health Reforms

Potential positive implications of the health reforms:

1. Increased access due to: (a) development of alternative sources of care;

- (b) increased funding; and reallocation of public funds from curative care to primary health care.
- 2. Improved affordability due to competition.
- 3. Improved quality of care due to increased competition and funding.
- 4. Increased risk sharing possibilities through development of alternative financing schemes such as insurance.
- 5. Empowerment due to participation in the financing and management of services.

Potential negative implications of the health reforms:

- 1. Limited access to the poor.
- 2. Motivate consumers to make unreasonable demands and develop high expectations.
- 3. The VAT will increase cost of health inputs.

Franchising: A New Initiative to Expand Private Provision of Care (Day 2)

Mr. Musowe and Dr. Bekele gave a short presentation on basic features of franchising and its application in the health sector. Its potential application to expand services to underserved areas and increase competition in others were discussed. Franchising has the potentials of solving some of the constraints to private sector development such as the limited access to credit, quality control, training, management of a business enterprise, lack of the benefits of economies of scale in small operations, supervision, and health information. All of the above constraints can be eliminated, or at least relaxed, by a franchising arrangement.

Constraints and Solutions for Development of Public/Private Sector Partnership

Five working groups were formed to identify major constraints and suggest solutions. Some of the key constraints and suggested solutions by working group, are given below:

On Political and Legislative Matters:

Major problems include:

1. Lack of political consensus and inconsistency in commitment to reforms;
2. Fragmented and outdated legislation governing medical practice; and
3. Lack of enabling legislation.

Some of the solutions recommended include:

1. Lobbying and sensitizing politicians;
2. Harmonizing and updating existing legislation; and
3. Drafting and enacting enabling legislation.

On Strengthening Public/Private Sector Linkages:

Major problems include:

1. The traditional sector is not covered by appropriate legislation, lacks facility for training and research and development, and suffers from social stigma and mistrust;
2. Modern private sector operates under restrictive laws, lacks incentives, management skills, and suffers from high taxation;
3. Mistrust between the public and private sector persists, referral between the two sectors is poor, and formal linkages between the private sector and MOH do not exist.

Some of the solutions recommended include:

1. Enact enabling legislation, and provide institutional support for the development of traditional medicine;
2. Create an enabling environment for development of modern private practice including review of existing laws and amending them as needed;
3. Develop a formal link between the two sectors.

On Financial and Economic Constraints:

Major problems include:

1. Delinquency of GRZ in settling its debt to private sector;

2. Poor financial management skills in public facilities;
3. Low per capita income, as well as low per capita public expenditure on health;
4. Failure in sharing scarce resources;
5. Barriers to entry, especially financial;
6. Poor marketing skills in the private sector; and
7. Anomalies in the tax laws that are prejudicial to private sector activity.

Some of the solutions recommended include:

1. GRZ should clear debts, adhere to cash budgeting, and strengthen financial management skills;
2. Improve targeting mechanisms, and increase allocations to health;
3. Publicize availability of equipment and develop procedures for sharing of resources;
4. Explore franchising possibilities; and
5. Remove anomalies in the tax laws.

On Human Resource Issues:

Major problems identified were:

1. Insufficient number and poor distribution of trained health personnel;
2. Inadequate training capacity;
3. Inadequacy in management skills;
4. Low standards of practice in private sector; and
5. Ineffective in-service training.

Some of the solutions recommended were:

1. Expand training capacity and rationalize personnel deployment;
2. Require management training of top-level staff;
3. Develop in-service training capacity; and
4. Develop a human resources policy.

On Constraints Related to Commodities, Medical Supplies, and Pharmaceuticals:

Major problems identified were:

1. High cost of local production;
2. Delinquency of the GRZ in settling debts;
3. Lack of a rational and comprehensive national drugs policy;
4. Inadequate capacity for local production of pharmaceuticals; and
5. Poor transport and distribution network.

Some of the solutions recommended were:

1. Develop local capacity of production; review the tax on imported inputs; review policy on ceiling of retail mark-ups;
2. Timely settlement of GRZ debts;
3. Redefine role of the Central Medical Stores, and encourage development of the distribution system through franchising; and
4. Encourage and foster contractual arrangements to resolve the transport and distribution problem.

Follow-up of Conference Recommendations

A task force of 5 members drawn from MOH, GPs, THPAZ, CMAZ, ZCCM, the Nursing Council, the Medical Council, representatives of consumers, and the University would be appointed to work with the MOH on the follow-up of implementation with conference recommendations.

Conference was officially declared closed by the Honorable S.S.S Miyanda (MP).

Part 1: Introduction

In 1991, the Government of the Republic of Zambia (GRZ) embarked on a program of economic and political reforms. The program of reforms was necessitated by a poor resource picture and was designed to open the economy to greater competition and the political process to greater public participation.

In the health sector, the need for reform was driven by the sustained erosion, beginning in the late 1970s, of the impressive health gains made in the immediate post-independence years. Mortality rates, including infant and maternal mortality rates were rising. The reasons for the erosion in health status are complex. They range from increasing disease virulence, the emergence of new diseases, and increasing vulnerability to vector-borne diseases as a result of cutbacks by the state on social expenditures. However, the ability of the government to respond adequately to these new health challenges was severely constrained by its poor fiscal state. As a result, Zambia's weak health infrastructure was unable to adequately meet the rising demand for health services. In the Ministry of Health, the deterioration in health status, the poor resource picture and the liberalized political climate have combined to create an environment in which policy makers are willing to explore alternatives to traditional methods of organizing, delivering and financing health care.

The Health Reforms

A number of attempts have been made in the past to address the problems in the health sector. For a variety of reasons, including inconsistency in policy implementation and lack of political will, these earlier attempts failed. In 1991, with the election of the Movement for Multiparty Democracy (MMD) into office, and against the backdrop of the political and economic liberalization policies the new government introduced, the Ministry of Health embarked on a wide ranging assessment and mapping of the future of the health sector. The objective of this exercise was to reverse the erosion in health status, and to improve and sustain the delivery of quality health services to the Zambian people.

The assessment included a review of the role of the government as a provider and financier of health care, the role of the nongovernmental/private health sector and the Ministry of Health in the health care delivery system. It also included an assessment of the resources required to arrest the decline in Zambia's

health indicators. The review resulted in the development of an innovative package of reforms aimed at mobilizing additional resources for health and improving efficiency in the delivery of health services. These and the strategies for implementing them are summarized in two important policy documents: *National Health Policies and Strategies 1991 and National Strategic Health Plan 1995 - 1999*. The objective of these reforms is to provide Zambians "equity of access to a cost-effective, quality assured health care as close to the home as possible". One important component of the reforms is partnership between the public and private sectors in the financing and provision of health care to better meet Zambia's national health goals.

The Private Sector

Except for health services provided by church-affiliated health institutions, private provision of health care in Zambia is at a nascent stage. Its development was constrained by the nationalization of health services by the immediate post-independence government. However, recognition of the inefficiencies of public provision, the fiscal crisis, and an acknowledgement of the existence and contribution of private providers to Zambia's aggregate output of health services have provided a basis for the GRZ to rethink its attitude to the private health sector. It is now considering how best to harness the sector's potentials to achieve national health goals.

Some preliminary steps have been taken in this direction. The MOH participated in a conference sponsored by the World Health Organization (WHO) on "Public/Private Mix in the Delivery of Health Services" held in Windhoek Namibia in 1993. It collaborated with the Data for Decision Making Project (DDM) at Harvard University on a study sponsored by the Health and Human Resources Analysis for Africa (HHRAA) on "Nongovernmental Health Care Provision in Zambia". It also participated in a "Conference on Nongovernmental Health Care Provision in Africa" held in Nairobi, Kenya in December, 1994. This conference was sponsored by HHRAA and organized by DDM.

Zambia National Conference on Public/Private Partnership For Health

"Zambia National Conference on Public/Private Partnership For Health" was sponsored by the MOH. It was held in Siavonga from June 8 - 11, 1995. Funding for the conference was provided by the USAID mission in Zambia. DDM at Harvard University and the HHRAA Project of the Africa Bureau USAID/Washington provided technical assistance. Rolf Sartorius of Team Technologies, Inc. acted as facilitator. It was attended by over 60 participants from various

Government agencies, the Church Mission Association of Zambia (CMAZ), Zambia Consolidated Copper Mines (ZCCM), pharmaceutical manufacturers, unions, the University of Zambia, and private surgeries and hospitals. Among participants were: the Permanent Secretary in the Ministry of Health, Dr. Kamanga; the Zambia Resident Representative of the World Health Organization (WHO), Dr. Boayue; and a member of Parliament the Hon. S.S.S Miyanda. The full list of participants is in Appendix 5.

The objectives of the Conference were as follows:

- To provide a forum for government to express its commitment to forging partnerships with the private sector;
- To offer various components of the private sector the opportunity to communicate with government and express their vision for a harmonious partnership;
- To define the contractual relationship between government (as purchaser) and private sector (as sellers of care);
- To identify constraints to the development of the private sector and explore feasible solutions;
- To recommend appropriate policy reform for maximizing private sector (provider) participation in the public health agenda to more cost-effectively and efficiently achieve national health goals.
- To identify critical next steps in the development of public/private sector partnership, develop an implementation plan, and assign tasks.

Part 2: Opening Ceremony

The Conference was chaired by Dr. Kawaye Kamanga, the Permanent Secretary in the Ministry of Health, and was declared open by the Hon. (Dr.) Katele Kalumba (MP), Deputy Minister of Health. It was officially closed by the Hon. S.S.S Miyanda, (MP). The formal opening of the Conference was preceded by three short remarks. These were the Chairman's opening remarks, remarks by Mr. Rudolph Thomas, Acting Director of the USAID mission in Zambia and Dr. Abraham Bekele, senior health economics and financing advisor, the Africa Bureau, USAID in Washington.

Welcoming Statement by Dr. Kawaye Kamanga, Permanent Secretary, Ministry of Health

The Permanent Secretary welcomed participants to the Conference. He provided some background to the health reforms and explained efforts made so far by the MOH to translate the reforms from vision to reality. These efforts include the reorganization of the MOH. The new MOH, the Permanent Secretary explained, has devolved its responsibilities for policy implementation and monitoring to newly created district health management boards (DHMB) and hospital boards.

Partnership between the state and the private sector in the financing and provision of health services is another component of the health reform. He explained that with the limited introduction of cost sharing in public health facilities and representation of members of the public on DHMBs some success has been achieved with regard to partnership (with the public as private financiers of health care) in health financing. A lot remains to be done in regard to partnership with the private sector in the provision of health services. The Conference represented a practical first step in that direction. He advised that caution must however be exercised in this area since it is characterized by many unknowns arising from a) limited world-wide experience b) the poor health of the economy and d) limited information on the private provision sector; its size, distribution, structure, conduct and performance.

In closing his remarks, he urged participants to resist the temptation to allow their debates to degenerate into two opposing camps - for and against public or private provision of health services, and to come up with recommendations that will assist the MOH design policies that will encourage private provision of

health services.

The full text of Dr. Kamanga's remarks is in Appendix 1.

Opening Remarks by Mr. Rudolph Thomas, Acting Director, USAID Mission to Zambia

Mr. Thomas praised Zambia's health reforms and applauded the leadership, courage and consistency of the MOH in implementing the reform program. He assured the MOH of USAID's support, to health reforms in general, and public/private sector partnership initiatives in particular. He also disclosed that USAID will program approximately USD70 million in the next several years to support Zambia's health reform program and that USD20 million will be made available in the next few weeks to support Zambia's Child Health Project. It was USAID's hope that its assistance in general and the Child Health Project in particular will help the MOH strengthen private/public partnership in health services delivery.

Finally, Mr. Thomas expressed the hope that the Conference will come out with a set of concrete policy-relevant recommendations and a plan of action in support of an effective and mutually beneficial public-private sector partnership for health in Zambia.

The full text of Mr. Thomas's remarks is at Appendix 2.

Opening Remarks by Dr. Abraham Bekele, Sr. Health Economics and Financing Advisor, HHRAA, AFR/SD/HRD, USAID/W

Dr. Bekele praised Zambia's health reforms. He recalled the history of his contacts with the officials of the Ministry of Health. He also thanked them for the opportunity to work in Zambia. He explained to conference participants that the big unknown in health economics today is understanding the size, scope, distribution and contribution of private and nongovernmental health care providers to national health goals. He also apprised participants of the role that the HHRAA Project of the Africa Bureau, USAID/W, is playing in addressing this gap in knowledge.

Citing challenges to the Zambian health sector posed by changes in the epidemiological profile and the poor economic conditions, he reminded conference participants that what is at stake is Zambia's health system as a whole. He accordingly urged conference participants to stay focussed on the issue of public/private partnership in the health reforms and how best the partnership can

best be harnessed to address the challenges in the health sector.

Finally, Dr. Bekele expressed his appreciation to the USAID mission in Zambia, the Minister of Health and to all who have contributed to making the Conference possible.

The full text of Dr. Bekele's address is in Appendix 3.

Health Care Reforms: Meeting the Challenge for Partnership: Opening Speech by the Hon. (Dr.) Katele Kalumba (MP), Deputy Minister of Health

The Hon. Deputy Minister's address focussed on the political and economic environment of the health reforms. In it, he acknowledged the support of the donor community for the reform effort and described the political environment in which the reforms are being undertaken. He pointed out that health reforms in Zambia have a long history and suggested some conditions necessary for a successful outcome of the reform effort.

The Minister noted that although there has historically been widespread recognition in the country of the need for reform in the health sector, the political climate surrounding the health reform remains turbulent and uncertain. He identified the two main sources of the turbulence and uncertainty as a) external factors beyond the control of the Ministry, and b) the interdependent yet adversarial relationship between providers, government ministries and nongovernmental organizations as they struggle to influence the allocation of increasingly scarce resources. He warned that the reform program was likely to be adversely affected if the political environment is not carefully managed by the MOH.

He recognized that some elements of the reform program have become a source of concern to some segments of the population, in particular the limited introduction of cost-sharing in public facilities. These concerns, the minister said, reflected the fragility of the national consensus for health reforms. They also revealed the technical and political challenges in managing the implementation of the reforms, thus highlighting two political prerequisites for a successful outcome of the reform effort. First, health policy managers must be sensitive to political realities including the political calendar and second, the political leadership of the Ministry of Health must, on technical issues, defer to the technical advice of professionals before policies are announced.

The Minister further stated that the health reforms have been designed to bring about the reallocation of resources, improve the infrastructure, decentralize authorities and financial control and the complete overhaul of the manner in which health services are delivered in the country. In addition, the reforms also

aim to explore ways which will enhance community participation in decision making and tap into the resources of the private sector in order to complement public sector financing of the production of staff and health sector research. Using the preceding as predicates, the Deputy Minister accordingly described the health reforms as the answer to many public concerns about the health sector and not the problem.

The Minister noted that there are several avenues in which government can collaborate with the private sector. One such area is in the financing of health care. He recognized however, that this potential may not be harnessed without a clarification of the GRZs health sector financing policies and modalities. This clarification he emphasized is a necessary precondition for tapping into the potential offered by the private health provision sector. He defined the building of mutually beneficial and complementary links between the government and the private sector as the new frontier of health reform in Zambia and urged participants to critically examine how government's taxation and expenditure policies may affect different aspects of private provision in general and public/private collaboration in particular.

The full text of the Deputy Minister's speech is in Appendix 4.

Part 3: Presentations and Discussions

Health Sector Reform/National Health Strategy by Dr. Sam Nyaywa, Head, HRIT, MOH and Mr. Vincent Musowe Chief Health Planner, MOH

The joint presentation by Dr. Nyaywa and Mr. Musowe was designed to explain the health reforms to participants: its impetus, steps taken to implement them, successes achieved and outstanding challenges. The objective was to provide a basis for an informed discussion by Conference participants, of the implications of the health reforms in general and for private health providers in particular, and to wit: including how best to elicit their cooperation and explore their potential towards achieving national health goals.

Dr. Nyaywa and Mr. Musowe presented evidence to show the deterioration in the health status of Zambians and the economic costs it was imposing on the national economy. HIV/AIDS had become a major cause of death and according to some projections will account for close to 76% of disability adjusted life years lost (DALYs). Child and maternal mortality rates have been rising, with some recent studies at University Teaching Hospital (UTH) showing a maternal mortality rate in Lusaka of 415/100,000. This is a more than 100% increase from previous estimates of 200. In addition, about 12% of babies born are of low birth weight. The health status of Zambians has also been compromised by factors such as malnutrition (which accounts for between 20 - 30% of all hospital admissions), inconsistently implemented immunization campaigns, inadequate access to safe drinking water and poverty.

However, while the health indicators were deteriorating, the health infrastructure, for structural and other reasons, has been unable to meet the increased demand for health care. The scope for increased budgetary allocations was limited because of the poor fiscal state of the country. At the moment, Zambia's per capita health expenditure is US\$12.00. The health reforms were therefore a deliberate response to the challenges in the health sector.

Several components of the reforms, have already been implemented. The structural reorganization of the Ministry of Health which involved the devolution (decentralization) of its responsibilities for implementation and monitoring to

lower level administrative bodies (newly created district health management boards) has been completed. As a consequence, the MOH has also effected the reallocation of the health budget in favor of lower level health institution and reorganized the referral system. To assist the districts carry out their new responsibilities effectively, the Ministry carried out a successful program of capacity development at the district level. Equally important is the MOH's success in securing a 5% increase (from 8 to 13%) in health's share of the national budget.

Furthermore, two very important components of the reforms, in terms of their implications for private provision of health services, have been implemented. These are the limited introduction of cost sharing in GRZ¹ health institutions and the development, based on the ten most common causes of death in the country, of an essential package of care. The cost sharing scheme permits medical institutions to raise revenues by charging medical fees. This frees up resources from the major hospitals for reallocation to lower-level health facilities as revenues so raised are retained by the health institution and are not additive to their share of the health budget. Such revenues may be used for facility improvements and in some cases to award bonuses and other incentives to deserving staff.

The essential package of care was developed in response to the GRZ's growing inability, due to the poor resource picture, to continue to finance all types of care. The GRZ will pay for all health services in the essential package; all other costly health services which may not have a significant effect on reducing the disease burden are excluded. This thus presents an opportunity for greater private health sector involvement in the delivery of care. The Conference, it was hoped, will generate ideas for how best the government can assist the private sector exploit its potentials for contributing towards meeting the nation's health goals.

Concepts and Issues in Public/Private Sector Partnership for Health by Abraham Bekele, Ph.D. USAID/AFR/SD/HRD and Peter Berman, Ph.D. DDM, Harvard University

The objective of this presentation was to acquaint Conference participants with the concepts and issues in public/private mix in the delivery of health services. The presentation began with an explanation of the interest in public/private sector partnership in health. Authors argue for an exploration of this approach due to the following factors: a) the poor resource picture of many countries; b) the failure of governments to provide adequate health care; c) the need to mobilize additional resources; and d) the changing epidemiological profile from infectious to curative diseases. Bekele and Berman further explained that the sources of government failure are varied but are generally attributed to: a) bureaucratic

1/ There is an exemption mechanism in place for the less well-off. They are expected to obtain certificates of indigency from the appropriate government agencies. Under-5 children are also exempted from fee-paying as are persons 65 and above.

inefficiencies; b) rent-seeking by interest groups and c) shortfalls in performance and outputs due to highly centralized and top-down service strategies.

Attention was drawn to imprecisions in the definition of the terms private and public in the delivery of health services. This imprecision stems from the heterogeneous nature of providers who range from religious organizations and other not-for-profit providers to the profit motivated provider. This caveat in place, Bekele and Berman defined as **public** all health facilities owned and controlled by various levels and agencies of government. The **private** sector is thus a residual category not under the direct control of the government. This category includes a large assortment of providers ranging from the part-time traditional healers and itinerant medicine vendors to the very complex private tertiary hospital. It includes small NGOs and large mission operated facilities or collection of facilities. Within the private sector itself, additional classification is possible. The private sector can be classified by a) commercial orientation into for-profit versus not-for-profit; b) therapeutic system into traditional and modern and c) organizational complexity ranging from part time single operator to highly complex structures such as health management organizations (HMO).

The definition permitted them to identify the following configurations in the provision and financing of health services: a) public provision and public financing, b) private provision and public financing, c) public provision and private financing, and d) private provision and private financing. They noted that each of these configurations has different implications for government policy since public and private interests are not always the same. Government policies which are likely to impact the private sector include: a) the decision of the public sector to provide and finance health services; b) the mechanism by which the public sector finances health services; c) the tax (and subsidy) regime. Furthermore, laws and regulation adopted by governments have a significant impact on the entry, location and pricing decisions of private providers.

Finally, the paper drew attention to areas in which the public and private health sectors can collaborate to their mutual benefit. Governments can increase access to health services by providing private health facilities with inputs such as ORS and contraceptives, permitting physicians in public service to engage in part-time private practice, or financing health services bought by the general population from private providers. However, they caution, collaboration may not always lead to improved health services. It is necessary for both sectors to be in healthy competition with each other. Competition will lead to quality improvements, higher productivity and cost containment. The main disadvantage of private provision of health services is that it might have negative welfare consequences; the less well-off might be left out of the health care system.

Panel Discussion on Public/Private Partnership: The Private Sector Perspective

A panel discussion by different private providers was constituted at the Conference. Its purpose was to provide the private health sector's perspective on the issues under discussion. Members of the panel were: Prof. Munkonge, Acting Dean School of Medicine UTH and Proprietor of Hilltop Hospital; b) Dr. Rodwell Vongo, Traditional Health Provider and President of Traditional Health Practitioners Association of Zambia; c) Dr. M. Banda, General Secretary CMAZ; d) Jamie Dodwell Zambia Association of Manufacturing and Pharmaceutical Industries (ZAMPI); e) Dr. G.B. Silwanda, Group Medical Consultant, ZCCM.

A. Presentation by Dr. Munkonge, Hilltop Hospital

Prof. Munkonge was at the conference in his capacity as the proprietor of Hilltop hospital, one of the three private hospitals in Lusaka. He began with a brief history of the hospital and then described its scope and activities and the constraints it faces.

Hilltop Hospital was established three years ago and is currently a 35-bed hospital with an average intake of 60 patients per month. Upon completion, its planned total will be 50 beds. The hospital has on its payroll 3 full-time doctors, 60 full-time nurses, 30 part-time nurses. Its aim is to provide individualized, specialized and internationally competitive health services to all health care consumers at a profit. Accordingly, its clientele consists of health consumers who are willing and able to pay. A corollary objective of the hospital is to provide a conducive environment for the practice of medicine in Zambia and thus help contain the medical brain drain to neighboring countries. The services provided by the hospital range from mother and child health to surgery.

Since inception, the hospital has had an active collaborative arrangement with the UTH and other private providers in the Lusaka area such as Monica Chyuma. It hopes that the range of such collaborative activities will continue to grow.

The following were identified as the major variables constraining the activities of Hilltop Hospital:

- i. Inadequate managerial skills such as in accounting, administration, personnel management etc. The inadequacy of a competent pool of such skills in the health area in the country was a major constraint;
- ii. Frequent and at times frivolous litigation by clients. Hilltop Hospital has been sued 50 times since its inception. The reason for the high incidence of litigation is "excessively high consumer expectations". Delays in the

performance of an operation and falls on slippery floors have been sufficient reasons for litigation. As a result of the large number of litigations, Hilltop hospital now devotes 33% of its revenues to insurance;

- iii. Discriminatory taxation. The GRZ levies a 35% tax on incomes of physicians who practice privately in Hilltop. No such tax is assessed on the incomes of private physicians who have admitting privileges at UTH. Further more, law enforcement authorities and the managers of public utilities are yet to recognize the existence of private hospitals. Electric power and water can be shut down without notice if there are delays in payment for services;
- iv. Lack of legislation on private ownership of ambulances is another constraint. There have been cases, when Hilltop's ambulances have been detained by the traffic police for running a red light on their way to UTH;
- v. Crime. There have been frequent invasions of the hospital by thieves and robbers. Requests to law enforcement agencies for greater protection have not been adequately responded to;
- vi. Lack of credit. While lack of access to credit was a major constraint, Hilltop Hospital, like other private providers in the country, does not want handouts or to receive direct funds from the GRZ; the reason being fear of future direct government intervention in the activities of the hospital. However, the GRZ will best assist the private health sector providers if it limits itself to introducing them to potential foreign investors and creditors.

Dr. Munkonge underscored the contribution that private providers were making to the achievement of Zambia's national health goals and their potentials to do more. These include decongesting public health facilities, conserving foreign exchange, and providing employment to Zambian medical professionals and thus helping to reduce the incentive for them to emigrate in search of greener pastures.

B. Presentation By Dr. Rodwell Vongo, THPAZ

Traditional healers represent an important source of care for many Zambians. Surveys undertaken by the Central Statistical Office (CSO) show that they are the primary source of care for about 10% of the population (Priority Survey 2, CSO, 1994). They are also a primary source of medicine for about 27% of the population (Community Survey, 1995).

Dr. Vongo emphasized the importance of traditional health providers. He contrasted traditional healing methods with western approaches, presented some evidence on treatment outcomes from his practice and urged collaboration

between traditional and the modern health sectors, emphasizing that the traditional health sectors was an integral part of Zambia's health system.

The Traditional Health Providers Association of Zambia (THPAZ) is a 35,000 member umbrella organization founded with assistance from the GRZ, in 1978. There are 4 main categories of traditional healers. These are: traditional midwives or birth attendants, faith healers or spiritualists, diviners, and herbalists. Patients come from all over Zambia referred to the healers largely through word of mouth. Major illnesses treated include: sexually transmitted diseases, psychiatric illnesses, tuberculosis, etc. There is a government agency, the Traditional Healers Unit at the Ministry of Health charged with responsibility to oversee traditional medical practice in Zambia. This Unit has however been largely ineffective.

Traditional healers face a number of constraints, primarily the failure of the government to institutionalize traditional medical practice as in Zimbabwe and other countries. Other constraints include: lack of funding, lack of explicit government policy (including an Act of Parliament) on traditional medical practice, lack of goodwill on the part of decision makers, lack of state funding for research on the efficacy of traditional herbs and medicines.

He called for dialogue between all groups of health providers to remove suspicion on all sides and also to demystify the traditional practice of medicine. Dialogue, he also submitted, will facilitate the sharing of knowledge between western-trained and traditional healers and help set up a referral system between both practices. He asked the government to assist traditional healers in standardizing training, controlling quackery, and stopping bogus advertising by some traditional healers of cures for AIDS.

C. Presentation By Dr. G. Silwamba, ZCCM

In addition to the GRZ and church affiliated health institutions, government parastatals and industrial establishments are also significant providers of modern health services in Zambia. The view point of this category of providers was provided by Dr. Silwanda, the Group Medical consultant of Zambia Consolidated Copper Mines (ZCCM) Ltd. ZCCM is the largest producer of health services among this group.

ZCCM operates ten hospitals and approximately 94 clinics. They are all, except for a small clinic in Lusaka, located in the Copperbelt. The establishment of these facilities was a response to the high economic cost of high morbidity and mortality rates from disease, especially malaria, in the Copperbelt in the early years of mining in Zambia. ZCCM health institutions provide a wide range of preventive, promotive and curative services. On the preventive side, they provide immunization services, health education, and also engage in activities to

control communicable diseases. In addition, ZCCM provides potable water to the communities in which it operates and participates in environmental control programs. Specialist care is provided in a wide range of areas spanning surgery, obstetrics/gynecology, anaesthesia, orthopaedics, paediatrics and medicine. In other areas such as otolaryngology, ophthalmology, pathology and radiology, specialist care is provided on a rotational basis and on request.

Services provided in ZCCM health facilities are of very high quality. In the next several weeks ZCCM will receive a catscan which will further improve the diagnostic ability of the health facilities. However, access to ZCCM health facilities is restricted to miners and their immediate families. Services are provided to non-miners on a fee-for-service basis. Accident and emergency victims can be treated in ZCCM facilities. But such patients are soon transferred to a GRZ health facility if they are found unwilling or unable to pay. A bill will subsequently be sent to the GRZ for services rendered.

Although ZCCM health facilities may be the best funded in Zambia, they nevertheless experience a number of constraints in the provision of health services. These constraints stem largely from inadequate funding and are manifested in a number of ways including but not limited to shortages of: a) staff ; b) pharmaceuticals; c) equipment; and d) logistic support such as transport. The provision of services, on the clinical side, is constrained by inadequate consultation and collaborative use of available equipment among health care providers. This has resulted in underutilization of health resources in the sector as a whole and the country in general. Other constraints include: delays in payment for services rendered and the dissolution of the medical and education trust.

The new health policy environment presents ZCCM health facilities with a number of opportunities. They could charge appropriate fees for services rendered and provide health services to the general public on a competitive fee-for-service basis as well as share their facilities, (medical laboratory, and consumables) with Government hospitals, Councils and Private clinics. Opportunities for clinical and other consultations between specialists in Government and ZCCM facilities will be enhanced. Such consultations will include interactions at the policy level and the holding of joint clinical meetings.

Concluding, Dr. Silwanda pointed to areas in which mine hospitals have been collaborating with the public sector. These areas include a) active involvement in the operations of District Health Management Teams; b) training of nurses for both the public and private sectors; c) close collaboration between ZCCM public health departments and its public sector counterparts.

D. Presentation By Dr. Mazuwa Banda, CMAZ

Church-affiliated (mission) health institutions are an important component of

Zambia's health system. They are, as a group, the second largest producer of health services in the country after the GRZ. Dr. Banda's brief presentation was designed to apprise conference participants of the activities of this group of providers and the constraints that they face.

There are 30 hospitals and 60 rural health centers affiliated with 16 Christian denominations. These health facilities, although mainly located in rural areas are evenly distributed throughout the country and can be found in 39 of Zambia's 60 districts. Coordination among the denominations and the health facilities is carried out by an umbrella organization, the Churches Medical Association of Zambia (CMAZ).

Church-affiliated health facilities account for 30% of the country's hospital bed capacity and about 40% of all outreach activities. Mission health facilities provide a broad spectrum of services ranging from preventive to promotive and curative services. They also provide rehabilitation and other specialist services and operate 9 nurses training institutions. Informal, on the job training, is provided for other categories of health personnel such as laboratory assistants, traditional birth attendants, and community health workers.

Mission facilities receive financial support from a variety of sources. The Government of Zambia through a grant process is the largest source of funds. Grants from the GRZ account for about 50% of the recurrent budget of the church health sector. In addition to the financial grants, the GRZ also seconded health professionals to church affiliated health institutions. The wage cost of seconded staff is borne by the MOH. External sources, an important source in the early years of the history of these facilities has declined with the indigenization of the churches. Much of the external support that the facilities now receive is tied to specific capital or other infrastructural projects. The facilities also receive external support in the form of commodities, volunteer doctors and other health personnel.

Dr. Banda emphasized the important role church affiliated health institutions are playing in providing health services in locales in which there is no government presence and the potential for them to do more. In his view, church-affiliated health facilities represent an important resource which the GRZ can effectively harness in its efforts to provide health services closer to the Zambian people.

He noted however, that the ability of the sector to contribute to national health goals is constrained by a) unstable sources of funding; b) lack of clarity in its relationship with the Ministry of Health and lower level administrative units; and c) inadequate staffing.

E. Presentation By Jamie Dodwell, ZAMPI

The Zambia Association of Manufacturing and Pharmaceutical Industries (ZAM-PI), Mr. Dodwell explained, is a one month old trade grouping set up to advance the views and interests of its membership to government. The association currently has a membership of about 25. It hopes to work to ensure optimum standards in the pharmaceuticals sector, and, working closely with the Pharmacy and Poisons Board, assure good quality of pharmaceuticals products in the country.

Members of the association are located largely along the line of rail. There are two major problems confronting members. The first is the problem of late payment for supplies by the Ministry of Health. The second is an uneven playing field between importers and manufacturers due to discriminatory taxes and import duties. Domestic producers are faced with high taxes while importers of finished drugs pay virtually no duties.

Mr. Dodwell noted that the ready availability of drugs is a prerequisite for a well-functioning quality-conscious health sector and emphasized the potential role that manufacturers of pharmaceutical products in Zambia could play in realizing the objectives of the health reforms.

Comments On The Minister's Speech And Discussion on the Presentations

The Deputy Minister's Speech

The Deputy Minister's speech was well received by conference participants. Participants agreed with his characterization of the health reforms as a solution to the problems in Zambia's health sector. Participants also agreed that his emphasis on the importance of a national consensus for health reform and the need for professionals in the Ministry of Health to be sensitive to the political calendar were very timely. Participants noted that his speech raised some important questions. These questions include: a) are private hospitals actually needed? how do they fit in?; b) is a common, shared agenda between public/private possible; c) how can a national consensus for health reforms be achieved; d) how will the less well-off in society be affected by the reforms; and e) how best and cost-effectively can the nation be educated on the merits of cost-sharing and prepayment schemes?

Presentations

A participant asked Prof. Munkonge if the harmonious relationship between Hilltop and UTH was not a derivative of his personal relationship with both institutions. Another participant asked to know how the tax structure affected practice at Hilltop Hospital. Responding to the questions, Dr. Munkonge suggested that collaboration between UTH and Hilltop and between Hilltop and other private providers was not dependent on him but is driven by their mutual recognition of their interdependence and the benefits of cooperation and collaboration.

Addressing Dr. Vongo, participants wanted to know what the qualifications of the members of THPAZ association were and why they addressed themselves as doctors. In response, Dr. Vongo explained the direct English translation of the word ng'anga, the traditional title for healers, was doctor. He expressed surprise that a society which was willing to call animal healers "doctors" finds the use of that title by traditional healers to be a source of disquiet. He disclosed that THPAZ was making concerted efforts to rid itself of quackery. With some funding from USAID, it has been able to compile a register of healers in some districts. With additional funding, the exercise could be extended to many more districts of the country. Traditional healers are willing to collaborate with western-trained physicians and have taken practical steps in that direction. For instance, a number of years ago healers made herbs available to the modern sector for testing. Unfortunately, they were yet to get feedback. He called on the government to fund research on dosage and the efficacy and toxicology of local herbs in the treatment of various diseases.

Dr. Hilda Mutyarbarwa, the President of the Lusaka faculty of General Practitioners (GPs) expressed concern at the lack of representation of general practitioners represented on the panel. She submitted that the 140 general practitioners in Zambia, who see an average of 20,000 patients a day in their 240 registered surgeries, were making a substantial contribution to Zambia's national health goals.

Other participants pointed out that the logistics for private sector partnership were still to be worked out. A much more precise definition of the relationship between the public and private sectors was required. CMAZ expressed its discomfort with being associated with the term private; church-affiliated health institutions would like to be considered a "special category" of health providers, especially in light of the fact that a substantial percentage of their funding comes from the GRZ. A participant noted that the long-term success of the reforms depends on its being understood and appreciated by future

managers of the health system and their commitment to its objectives. Accordingly, he suggested that the health reforms should be constantly explained to the public and health practitioners and taught to medical school undergraduates at the University of Zambia.

Working Groups

With these presentations as background, participants were later constituted into working groups to discuss the issues raised in detail, in particular the implications of the health reforms for private provision of health care. The following 3 groups were constituted: Group 1 focussed on the implications of the health reforms for the private health sector; group 2 was assigned the task of assessing the role of the private sector in the new reforms; and Group 3 focussed on the likely impact of the reforms on the consumer. Each group met separately to discuss the issues and reported back to the plenary with a summary of their discussions. These are presented below.

Group 1: Health Sector Reforms and their Implications for the Private Sector

Chair: Dr. Munkonge, Facilitator: Dr. Nyaywa

The assignment of this working group was to examine the implication of the health reforms for private providers. Since the effects of the reforms may vary from provider to provider, the group began its assignment by first identifying the various actors that make up the private provision sector. The following were identified: individual households, traditional healers, community-based health workers including distributors of commodities, drug stores, pharmacies, other practitioners (such as clinical officers, nurse practitioners, physiotherapists etc.); general practitioners (private surgeries); private hospitals and nursing homes; and industrial hospitals.

The group found that *Households* will be substantially affected by the health reforms. Cost sharing will shift a percentage of burden of health financing to the household. Women as the primary care givers in the household may be overburdened since they will invariably be the main providers of care at the household level. The reforms will challenge the traditional health sector to be more dynamic and innovative and to contain costs. The reason for this is that there will be increased competition within the traditional health sector and between traditional healers and new privately owned western health facilities for patients. Fee paying patients will on the other hand will be more discriminatory

in their choice of provider as they increasingly exercise choice in their consumption of health services.

The group also found that the reforms may give impetus to the growth of *Community-based distributors* (CBDs). Their role may be enhanced by the reforms as they will complement the activities of the household in the production of health services. The Group cautioned however that the state may need to introduce some regulations and guidelines to maintain the quality of goods. Alongside CBDs in the provision of health commodities to the household are drug stores and pharmacies. The Group recognized that the reforms will have an observable impact on these groups. It was the Group's view that this sector will grow and that its growth will be beneficial as it will introduce greater competition and may reduce prices. There was, however, a need for improvements in quality surveillance to ensure that expired and dangerous drugs are not sold to the public.

Finally, on general practitioners and privately-owned hospitals, it was the group's view that the reforms will result in substantial growth of this group of providers. Growth in this sector along with the introduction of private practice by nurses and clinical officers, the group believes, will enhance access to health care. Competition among the various groups of providers would foster competition which would lead to quality improvements in the delivery of care and lower prices.

Group 2: The Role of the Private Sector in the New Reforms

Chair: Dr. G. Silwamba

It was the view of this group that the private health provision sector has an important role to play in Zambia's on-going health reform effort. It will provide additional health services to the country. Moreover, competition between the private sector and the public sector and within the private sector itself will lead to quality improvements and innovation in the health sector as a whole. The group however agreed that the sector will need substantial assistance from the GRZ if it is to fulfill this role. The group recommended that the MOH a) review and update restrictive company/private sector regulations; and b) improve and institutionalize communication between the public and private sectors. This could, for example, be done through mechanisms that permit physicians and other health practitioners in both sectors to attend each other's clinical conferences. The Group further recommended that the MOH may consider contracting out services such as immunization; laundry services, catering and pharmaceutical

supplies to the private sector; and liberalizing private practice of medicine by granting leave to health professionals such as nurses, midwives, clinical officers, radiographers etc. to engage in private practice. The group also recommended that the GRZs should encourage local manufacturing of pharmaceutical and related health care products and identify inefficiencies and waste in the procurement supply and use of drugs and other pharmaceutical products. Finally, the group recommended that the MOH should constitute a task force to oversee the public/private partnership in health and undertake a situational analysis or surveys to better identify the type of health care services that it believes the private sector will be better able to provide.

Group 3: Consumers and the Health Reforms

Chair: Hon. S.S.S. Miyanda

This working group considered the implications of the health reforms and the potential consequences for the consumer of partnership between the public and private sectors in the provision of health services. It began its assignment by first providing a working definition of the consumer of health services. According to the group, the consumer is the general population or all consumers of health services. It was the group's view that the reforms in general and partnership between the public and private sectors in the provision of health services will have positive and negative effects on the consumer.

Positive effects will include improved access to health facilities, more affordable health care and the institutionalization in the country of individual responsibility for own health. On access, it was the group's view that the reforms, by encouraging the growth of the private sector, will result in an increase in the number of health facilities in the country. This will improve nominal access to health facilities for health care consumers. Another way in which the health reforms will improve access is through the indirect effect of public sector focus on the essential package of care. The GRZ, by concentrating on this and leaving high-cost treatment to the private sector, will increase access to health services by the poor.

Concerning affordability, it was the group's view that growth in the private provision sector will spur competition in the health system. One beneficial effect of competition, in addition to quality improvements, will be cost containment and a reduction in the price of care. This, the group believed, will make health care more affordable to the Zambian people. The group also felt that insurance and prepayment schemes that may sprout as a result of these reforms

will also have a beneficial effect on the consumer. Finally, the most important impact of the reforms will be felt at the household level. The health reforms, by empowering citizens through cost-sharing and other schemes will permit them to exercise greater control and responsibility for their own care. This will, in addition to influencing consumer behavior, make consumers more demanding of high-quality services for payments made.

The group also identified some potentially negative implications of the reforms. One possible negative effect from an equity perspective is discrimination. The poor and the indigent may be discriminated against in terms of the types and quality of services provided. This might lead to consumer apathy, cause the poor to postpone seeking care or to drop out of the health care system altogether. Furthermore, payment for services provided may lead the consumer to demand unreasonable and exaggerated outcomes. For instance, consumers may expect or demand to be cured of terminal illnesses (instead of effective management of the illness). Finally, it was the group's view that the assessment of taxes on health services (through the VAT) will adversely affect the consumer through its effect on health care cost.

Part 4: Follow-up Action

One of the main objectives of the Conference was to suggest specific follow-up actions to the Government. To motivate the discussion, a brief presentation on franchising of health services was made by Mr. Vincent Musowe and Dr. Abraham Bekele. Franchising is increasingly looked upon in the health sector as one possible way of reducing some of the constraints impeding the development of private provision of health services.

Franchising is an arrangement which allows an individual to do business under the name of the corporate image of a national firm. There are two principal actors in a franchising arrangement: the franchisee (the one operating under the business name) and the franchisor (the one whose business name is being used) with the government through the judicial as the enforcer. Under a franchising arrangement, the franchisee agrees to provide productive inputs to produce a set of services under terms and conditions agreed-to such as prices and quality with the franchisor. In return, the franchisor agrees to provide training, a commonly recognized brand name, advertising and supervision. Disagreements between the franchisor and the franchisee are resolved by the state through the court system.

Franchising arrangements have a number of advantages. The most important are its ability to ameliorate the credit constraint and provide standardized training for all franchisees. Furthermore, it also reduces the average cost of producing the services since the cost of a number of activities such as advertising are collectively borne by the group. Lastly, franchising arrangements also help to ensure quality since the franchisee agrees to produce according to previously-agreed-to standards of quality.

Subsequent to the presentation, five working groups were constituted to discuss the constraints to private provision identified by participants. The working groups were also required to recommend appropriate solutions for consideration by government, identify possible implementing agencies and to suggest a time frame for taking action on the recommendations. Working groups were set up in the

following areas:

- Political and Legislative Constraints;
- Strengthening of Public-Private Linkages;
- Financial and other Economic Constraints;

Group 1

Political and Legislative Constraints

<i>Constraint</i>	<i>Solution</i>	<i>Responsible Agency</i>	<i>Time Frame for Action</i>
<i>A. Political</i>			
1. Lack of Political consensus (within and between political parties)	Lobby MPs and sensitize the public and politicians	Ministry of Health	3 months
2. Inconsistency in political commitment			
<i>B. Legislative</i>			
1. Fragmentation of existing health services laws for example; <ul style="list-style-type: none"> - Public Health Act - Medical & Allied Practitioners' Act - Nurses & Midwives Act - Pharmacy & Poisons Act - Medical Services Act (1985) 	Review, harmonize, amend, repeal and expand as needed	Ministry of Health	1 year
2. Outdated Laws <ul style="list-style-type: none"> - Medical Practitioners & Dental Surgeons Fees - Medical Aid Societies & Nursing Homes 	Review, amend, repeal and expand as needed	" "	1 year
3. Lack of enabling laws for the health reforms	Draft enabling legislation for the health reforms	" "	1 year

Group 1 Participants: Alice Munalula, Rapporteur/Chair; S.S.S. Miyanda; Kafula; M. Banda; Kas Nwuke, Abe Bekele.

Group 2**Strengthening Public-Private Linkages**

Constraints	Solution	Responsible Agency	Time Frame for Action
<i>Traditional Healers</i>			
- Lack of legislation governing traditional practice	Enact appropriate legislation to regulate practice of traditional healers	THPAZ/MOH	1 year
- Lack of institution for training of trad. healers and research	Establish an institution for training & research and development on traditional medicine	MOH/MOE	5 years
- Social stigma & mistrust	Promote traditional medical practice & create awareness of their role	THPAZ	1 month-5 years
Mistrust between private practice & public service	Conduct pilot study on exchanged experiences at different levels	Task Force	6 months
Restrictive laws & legislation e.g. nurses/midwives act of 1970	Review existing laws to broaden the scope of practice	Med. Council, G.M. Council ZMA MAZ Pharmaceutical (?)	6 months
Lack of management skills	Access to capacity building for both the private and public sector	HRIT	1 month
Lack of incentives for private practice	Develop a program that would: - ease access to credit; - provide tax breaks - create an enabling environment to develop private practice - encourage private practice as opposed to state owned health care delivery - allow access to medical machinery and equipment; - allow secondment of staff to private facilities	Task Force	1 month
Lack of good referral system between private/public sector	A referral system should be put in place to ensure continuity of care & give feedback to the GPs	Task Force*	1 month
Lack of formal institutional link between private practice and MOH	Open channel of communication so that dialogue can take place between both actors	Task Force	1 month
High taxation of private practice	Review the tax codes which restrict the development of the private sector	Private Practice Association/MOH	1 month

Group 2 Participants: Dr. Hilda Mutayabarwa, Chair; T. Pensulo, Rapporteur; Dr. Bolla, Mr. Howells, Tshombela, T. Tembo, Dr. Munkonge, S.M. Ziba, B.J. Kamphasa

*A Task force was appointed to follow up on Conference recommendations.

Group 3**Financial and Economic Constraints**

Constraints	Solutions	Responsible Agency	Time Frame for Action
1. Non-payment by MOH for services rendered	- MOH to clear old debt - Ministries to improve adherence to cash budget No commitment beyond cash budget	MOH/MOF	Short-term
2. Some mismanagement of funds allocated to hospital boards	- Assistance in management planning - Strengthen mgmt skills in boards	Hospital Boards	Immediate/ Ongoing
3. Low per capita income (poverty)	- Improve targeted use of public welfare assistance schemes - Issue coupons for access to essential health services	MOCD/MOH	Medium
4. Low per capita spending on health	- Govt to increase proportion of budget allocated to health	Health Care Financing Group	Medium
5. Failure in sharing scarce resources	Publishing/listing available resources in medical bulletins and put in mechanisms for sharing	Federation of Hospital Boards	Immediate
6. High barriers to entry, especially financial	Franchising health clinics	PSI/GRZ/Private Sector	Medium
7. Poor Marketing skills for setting up surgeries	Franchising	MOH --> Cabinet	Medium
8. Anomalies in levies on medical imports between public & private sectors, e.g. import duty	Remove disparities		Medium

Group 3 Participants: Kaluba, J. Dodwell, B. Nyirend, (Chair), M. Mfume, L. Ndalamei, C. Mukkuli, (Rapporteur), R. Vongo, M. Phillips.

Group 4**Human Resources**

Constraints	Solutions	Responsible Agency	Time Frame for Action
Insufficient Trained Personnel - Low intake of training schools - Brain drain	Expand capacity of training institutions and improve conditions of service - salary structures and working conditions	Govt & private sector	Ongoing
Inadequate Staffing of Training Institutions	Provide enabling environment - occupational & health safety - provide facilities which enable basic services, supplies/drugs - adequate provision of buildings/space (relieve patient congestion)	Intitutional Management	Ongoing
Lack of Training Resources	- improve study of teaching resources - strengthen UTH teaching programs	MOH/Boards Private Sector	Ongoing
Distribution of Trained Staff	- appropriate placement of trained staff - equitable placement of trained staff - strengthen present staff to take wider responsibilities	MOH/Boards Private Sector	Ongoing
Lack of Managerial Skill in the Health System Public & Private	- chief executives and unit heads to be required to have management skills	Intitutional Management	Immediate
Private Surgeries-Low Standard of Practice	- those in private practice should have completed post-internship in rotation in major disciplines	- Medical Council of Zambia - Quality Assurance Committee - MOH - Nursing Council	Immediate implementation
Insufficient In-service Training	- improve conditions of service - improve working environment - improve local facilities for training	Govt & private sector	Immediate
Ineffective In-service Training	- training of trainers to conduct in-service training - larger institutions to invite others to their planned training sessions - health institutions to run own in-service sessions - compulsory attendance at in-service sessions - private institutions to attend gov't planned courses	MOH & private sector	In place at UTH extend to other institutions Immediate action
Lack of HR Development Policy	to develop HR development policy	MOH	1 year

Group 4 Participants: D. Young (Rapporteur), Dr. Silwamba (Chair), M. Singine, Dr. C. Musowe, Dr. W. Boayue, Dr. Baboo, B.M. Ngenda, E. Msidi

Group 5**Removing Constraints to Commodities, Medical Supplies, and Pharmaceuticals**

Constraints	Solutions	Responsible Agency	Time Frame for Action
1. Local products more expensive than imported products	a) research/situation analysis on the local capacity to manufacture especially those products relevant to the essential packages of care; b) review of policy/legislation on duty for raw materials, packaging materials & finished products c) policy/legislation on retail price mark-up ceiling	- task force - NDP steering committee - task force - NDP steering committee - as above	- start soon - up to 6 months
2. Non-payment/ slow payment by public sector to private sector for the health care products	- timely disbursement of funds by MOF to MOH - timely disbursements of funds by MOH to institutions - institutions to honor payment obligations to suppliers	- MOF - MOH - Health Institutions	- start soon - ongoing
3. Lack of an adequate, efficient National Health Shop	- re-define role of medical stores limited - provide mechanism for private/public sector, suppliers/providers coordination on determination of real (rational) national requirements - franchising	- task force - NDP steering committee - as above	- start July - take up to 12 months - take up to 12 months
4. Inadequate local capacity to manufacture pharmaceutical, medical supplies and related health care products	- encourage technology transfer - situation analysis as in #1 above	- task force/committee for NDP -MOH/MOC Investment center - MOF - individual companies & organizations	start July, 1995 as part of NDP development - ongoing
5. Transport & distribution network	- contractual arrangements between public/private sector suppliers (e.g. MSL using its distribution network to distribute products) - contractual arrangements with private sector for transportation & distribution beyond the district to periphery	- task force - committee on NDP - individual providers/suppliers	- framework to be ready by December, 1995 - actual arrangements to start by January, 1995

Group 5 Participants: Dr. Raj, (Chair); R.M. Kampamba, (Rapporteur); M, Ettling; G.E. Mundia

- Human Resources Constraints;
- Commodities, Medical Supplies and Pharmaceuticals.

The recommendations of each group are presented in the Tables below.

Discussion

The recommendations were fully discussed in plenary. On the recommendations made by Group 1, a participant asked to be given an example of political commitment. It was the group's view that one example would be the variance in the interests of the political leadership of the Ministry and the interest of the professional class in the implementation of the health reforms. It might be the case that the civil servants are not committed to the health reforms; that they might be touting the reforms because it was just a job. Addressing the issue of professional commitment to the reforms, Dr. Nyaywa, Head of HRIT, assured Conference participants that all the staff at the HRIT were committed to the reforms. He was supported by Dr. C. Musowe, who added that the MOH's main task now was to continue to educate new employees on the merits of the reforms in order to ensure their long-term success. On legislative review, Mr. C. Musowe disclosed that it was an integral part of the reforms. He explained that there are at the moment about 18 health sector laws in Zambia all of which are scheduled for review. However, the speed of their review depends on the legislative calendar and requests from legal review from other GRZ departments and ministries. The MOH, he further explained was concentrating in the meantime on ensuring an early passage of the enabling legislation for the health reform.

Participants also took issue with a number of the recommendations made by the second working group: a) on the time frame (5 years) for implementing policies aimed at removing the stigma associated with traditional healing practices; and b) the secondment of staff to private health facilities excluding missions. Conference participants agreed that 5 years was too long and that the MOH should address the problem of stigmatization of traditional healers as soon as possible. Dr. Vongo disclosed that THPAZ was also working to remove the stigma. With some funding from the USAID/Z, the THPAZ has been working with its members to register all traditional healers in three provinces. He hoped that the exercise will provide a data base of traditional healers and assist the THPAZ to root out quackery. Mr. Musowe added that it was crucial for Zambia to bring traditional

healers into the system. The health system, he argued will not be worse off from such a policy but will rather benefit since it will make it easier for the MOH to keep an eye on the sector. On the secondment of staff to private health facilities, participants expressed concern for its financial implications for the GRZ, especially since these facilities are for-profit organizations. Mr. Howell's, a member of the group, explained that the recommendation applied only in those instances when assistance from private providers will assist a district or a hospital meet its essential package of care obligations or in periods of outbreaks of epidemics.

Concern was also expressed by participants on a number of other recommendations. On advertising, a participant pointed out that the idea might be impracticable given the ethical restrictions on advertising by physicians. On debt, Mr. Musowe disclosed that debt inherited from the Second Republic was an issue for the Ministry of Finance to sort out. The MOH was making concerted efforts to liquidate all debts incurred since the reforms began. He further disclosed that the MOH was trying to reduce its use of debt to finance activities by doubling efforts to raise own revenues. On this issue and the funding of the health sector in general, a participant wondered if a cash budget was appropriate given the essential nature of health. The same participant also urged the Ministry of Health to search for innovative approaches to the problem of indigence, since the high incidence of poverty in the country makes it unlikely that government hospitals can rely to a high degree on revenues generated in-house. The participant further commented that irregular drug supplies, because of MOH's inability to pay for them on time, could undermine the health reforms. He urged the government to consider protecting the Zambian pharmaceutical industry as an infant industry.

Participants also pointed out a number of imprecisions in the recommendations. These include the recommendation on:

- a) franchising. It was pointed out that a number of intermediate steps must first be undertaken to determine the feasibility or otherwise of such arrangements;
- b) increasing the share of the national budget devoted to health; and
- c) mismanagement.

A participant wanted to know if the mismanagement was willful or as a result of lack of management skills. On this issue, an MOH official pointed out that such a characterization was improper since a recent

management audit of the 69 districts in the country found only two cases of mismanagement. These cases it was emphasized was not willful mismanagement but a result of inadequate skills

The urban bias of a number of the recommendations, particularly those that relate to human resources was also noted. A participant pointed out that it would have been more useful if the group that considered human resources constraints had taken account of the differences in human resources requirements between urban and rural Zambia. This is because the incentives required to encourage private practice will differ between urban and rural areas. The same participant also noted that the long-term success of the health reforms depended in large measure on the supply of medical personnel and pointed out that the poor wages of physicians in the public and mission sectors and the lack of alternative rewarding employment opportunities may reduce the attractiveness of medical professions to young Zambians. He suggested that the GRZ may wish to review the wages of physicians in government employment. On this last issue, Mr. Musowe disclosed that a new scheme of service has recently been announced for physicians and other health personnel.

Task Force

Finally, noting the imprecision of a number of the recommendations, the variance in the time frame for implementation recommended by different groups and the need to reconcile the recommendations, Conference participants *agreed* that a TASK FORCE of no more than 5 members drawn from both the public and private sectors, mission and unions should immediately be constituted to further improve the recommendations. The following organizations were recommended for membership of the Task force: MOH, the Faculty of General Practitioners, THPAZ, CMAZ, ZCCM, Nursing Council, Medical Council, Consumer Representatives, and the University.

Part 5: Closing Ceremony

The Conference was officially closed by Hon. S.S.S Miyanda (MP). Some brief closing remarks were made by Dr. Sikasula, Dr. Vongo and Mr. Miyanda.

Dr. Sikasula thanked participants for a productive conference. He praised the MOH for organizing the Conference and advised it to strive harder to better understand the private sector. He reminded the MOH that there was residual distrust and skepticism of its intentions in the private health sector given the history of its past attitude towards private provision of health care. He also advised the GRZ not to be unaware of the fact that private health providers are not philanthropists but business people who care about the bottom line. Partnership, he emphasized, should be approached in a businesslike fashion.

Dr. Vongo concurred with the Minister's characterization of the reforms as a solution to Zambia's health problems. He emphasized the need for collaboration between the modern and traditional health sectors. He urged the government to invest in research into traditional medicines not only because they are relied on by a significant proportion of the population but also because they are a national resource which must be harnessed. He noted that this may be difficult particularly against significant opposition from the Christian church. He reminded the church that traditional healers were also believers in God and hoped for better understanding between healers and the Christian church in the future.

In formally closing the Conference, Hon. S.S. Miyanda congratulated Conference participants for a very productive conference. He expressed the hope that as a result of the conference, effective ways could be found for bringing traditional healers into Zambia's health care system as is the practice in Zimbabwe. He assured participants that he will support the health reform bill in Parliament and that he will be committed to supporting the reform efforts. Finally, he thanked the USAID/Z for sponsoring the Conference.

Certificates of participation were handed to participants by the MP.

Appendix 1: Statement Made by Dr. Kawaye Kamanga, Permanent Secretary, Ministry of Health, Zambia

National Conference on Public/Private Sector Partnership for Health, 7 June 1995, Manchinci Bay Lodge, Siavonga

Hon. (Dr.) Katele Kalumba MP, Deputy Minister of Health,
Cooperating Partners in the Health Sector,
USAID - Conference Facilitators from Washington,
Conference Participants from the Public and Private Sectors,
Ladies and Gentlemen,

It is with great pleasure that I welcome you all to this First ever National Conference on Public/Private Mix Partnership for Health to be held in this country. It is indeed a milestone in the dynamic process of implementation of our health reforms.

Our health reforms are divided into three scenarios, namely:

- a) the logic and justification of health reforms;
- b) the vision and the conceptual framework; and
- c) the implementation strategies.

The three principles guiding our implementation process are **leadership, accountability and partnership**. To a large extent, the first two (namely, **leadership and accountability**) are vigorously being implemented through the process of capacity building, devolution of key ministry of health functions of planning, management, service delivery, funding/resource allocation and revenue generation.

Furthermore, soon major hospital boards will have discretionary authority for personnel recruitment, assignment of tasks, and allocation of resources. And, recently, the ministry completed the exercise of defining the roles of different organizational levels of health centers, district, provinces and the center.

All these efforts by the ministry were meant to put the ministry's house in order before turning to the very important issue of partnership with other health private providers both "for-profit" and "not-for-profit."

However, as regards, the partnership with health consumers, this has been achieved through the creation of district and hospital boards where health consumers constitute the main membership to these boards. Additionally, this initiative has been enhanced by the culture of cost-sharing which the ministry emphasizes should be seen as an instrument of empowerment rather merely for raising revenue.

Ladies and gentlemen, before holding this conference, a series of events have taken place which are relevant to the private/public mix initiative. The first was the drafting of health care financing document, titled "paying for quality". This document was used as an input to the nearly completed health care finance policy.

Second, in October, 1993, I and the then health minister, Hon. (Dr.) Boniface Kawimbe MP attended an international conference on private/public mix in Windhoek, Namibia.

Third, the Ministry of Health commissioned a study which was funded by USAID/Washington DC through health and human resources analysis for Africa under the direction of Dr. Abraham Bekele. A copy of the draft study document has been made available to all conference participants as background information material.

Fourth, while in Washington, for our negotiation with Ida of the World Bank for the credit facility in support of the implementation of health reform, I, Dr. Nyaywa and Mr. Musowe took time off our busy schedule to visit the Population Services International headquarters where we met its president. The main purpose of our visit was to explore the possibilities how PSI would assist us in franchising our private health care providers.

Fifth, in December Last year, Dr. Nyaywa, Mr. Musowe, Dr. Mwanza and Dr. Mazuwa Banda Attended a course in Nairobi, Kenya, on Non-Governmental Health Care Provision in Africa. Where They met Dr. Abraham Bekele of USAID Washington who has been clearly

instrumental to the holding of this conference.

As a follow-up of that Workshop, Dr. Abraham Bekele Visited us in February, 1995 to prepare for this consensus conference. This Visit was followed by the final preparations one in April when pertinent issues relating to this conference were concretised and finalized.

Conference Participants, it is necessary at the outset to draw a distinction between the health care financing and provision of health care. Services may be publicly financed and publicly provided (for example, the national health service here in Zambia), or privately financed and provided (for example private users of private services). However, Private finance may coexist with public provision (e.g. With user fees for government services) or public finance with private provision (e.g. With government contracts for use of specific private sector services). The Terms "private sector" and "privatization" can apply to either financing or provision of health-related activities.

Thus, the promotion of the private for profit sector during periods of structural adjustment may be problematic. Furthermore, given the limited experience with privatization of health services in developing countries and the even more limited evaluation and appraisal of such experiences, it is extremely difficult to conclude how successful such could be. The shortage of information and the great uncertainties both theoretically and empirically about how private providers and financiers in the developing countries would behave suggest that an incremental approach to privatizing services, combined with serious attempts to evaluate and monitor, would be advisable.

In this connection, as a first step non-clinical services elements such as drug sales, family planning, water supply, refuse and sewage disposal, laundry, catering etc. can be grouped together in the first tranche for contracting out to the private sector.

In Conclusion, demand for health care is highly income elastic. Thus, as income increases, demand grows more than proportionately and if public services cannot keep up with the increased demand, private sector provision of care tends to step in to fill this gap. Thus, private sectors flourish mainly during resource rich times, or at least among the resource rich section of communities.

It might be useful at the outset to indicate that it is very easy for the conference to degenerate into two traditional opposing camps for or against public or private sector providers.

What really is at stake, as a **health sector** i.e. Collectively both public and private providers is: How can we assure the **provision of equity of access to cost-effective quality health care as close to the family as possible** within our comparative advantages?

Clearly, the general objectives of this conference is to begin to resolve some of the challenges highlighted above. However, specific objectives are as follows:

- To provide a forum for government to express its commitment in forging partnerships with the private sector;
- To offer various components of the private sector the opportunity to communicate with government and express their vision for a harmonious partnership;
- To define the contractual relationship between government (purchasing and private sector);
- To identify constraints in the development of the private sector and explore feasible solutions;
- To recommend appropriate policy reform for maximizing private sector (provider) participation in the public health agenda to ensure that the health sector as whole is cost-effective and efficient, and to consider options for development of purchaser/provider relationships within the public system.
- To identify critical steps in the development of public/private sector partnership, develop an implementation plan, and assign tasks.

It is now my pleasure to invite hon. (Dr.) Katele Kalumba (MP), Deputy Minister of Health to officially open the Conference.

I thank you.

Appendix 2: Rudolph Thomas' (USAID, Acting Director) Speech

Zambia National Conference on Public/Private Sector Partnership for Health, June 8 - 11, 1995, Siavonga, Zambia

I am here tonight in my capacity as the Acting USAID/Zambia Mission Director on behalf of our Director Dr. Joseph Stepanek who is currently out of the country.

First of all, I would like to welcome all of you to this historic Conference.

(1) USAID/Zambia is pleased to co-sponsor, with the MOH, and to finance this first ever Zambian National Conference on Public/Private Sector Partnership for Health.

The Permanent Secretary, Dr. Kawaye Kamanga, has laid out (or will lay them out depending on the order of your presentations) six general objectives of this Conference, so I will not repeat them here.

However, I would like to say that USAID is pleased to have been able to finance a series of studies with Harvard University under our central Health and Human Resources Analysis for Africa/HHRAA project including a case study on Zambia entitled "Zambia: Non-Governmental Health Care Provision."

Several of the authors of that study, Allast Mwanza and Kasirim Nwuke, which was presented at an USAID-financed regional African "Non-Governmental Health Care Provision Workshop in Nairobi last December, are present here tonight for this conference.

(2) USAID/Zambia is also pleased that we are able to support, in coordination and collaboration with our bilateral and multilateral donor partners, the remarkable vision of the Honorable Minister and Deputy of Health, Dr. Katele Kalumba, to reform the Zambian Health Sector.

We agree with the MOH that it is now time to involve both the “not-for-profit” and “for profit” private health care providers in the MOH’s health reform process and that all sectors and political parties in Zambia ought to support the MOH’s extraordinary efforts to reform the health sector in a bi-partisan/apolitical manner, even in an election year, including rapid passage of the “National and District Health Services Act” in the next session of the Parliament. The health needs of all Zambians should transcend party politics.

In order to support the Zambian Health Reform process, USAID/Zambia intends to program approximately USD \$70 million over the next several years and to sign a bilateral \$20 million Child Health project with the MOH this month. One of the five major components of this project will be to help the MOH strengthen this Public-Private Sector Partnership for Child Health.

Together with the MOH and our donors partners, many of whom are present here, we hope this will increase, among other things, the private provision of health care services; expand socially marketed health care commodities, encourage corporate sponsorship of child health activities and private insurance; and help develop community-based income generation for distribution of child health commodities.

This Conference is the first step in the MOH’s effort to develop a strategy, with your input, to mobilize and involve the private sector in the health care reform process and the expanded provision of health care.

(3) USAID/Zambia in its support of the MOH, has not worked directly with many of you in the recent past and we may be meeting some of you for the first time. We hope that this Conference will change that and that we will all become partners together with the MOH and our donor colleagues in improving the health status of all Zambians.

(4) All of you must be aware that a conference of this magnitude does not happen overnight or without extensive pre-conference preparations. The vision, direction, and preparation for this Conference comes from the MOH, but we have provided several technical experts from USAID and Harvard University and a professional facilitator to help make this Conference a success.

I wish you well in your deliberations and look forward to receiving, as does the MOH and our donor colleagues, a set of concrete recommendations and a plan of action in support of an effective public-private sector partnership for health care in Zambia.

Thank you.

Appendix 3: Address by Dr. Abraham Bekele, Senior Health Economics and Financing Advisor, USAID/AFR/SD/HRD

Zambia National Conference, Public-Private Sector Partnership for Health, Siavonga, Zambia, June 8-11, 1995

Mr. Chairman, Honorable Deputy Minister, Mr. Thomas, Dr. Boayue, Mr. Musowe, Dr. Nyaywa, and fellow participants. It is indeed a privilege and a great honor to be part of this experience. This, to my knowledge, is the first national conference on public/private health sector partnership in sub-Saharan Africa. Zambia is once again leading the region in exploring innovative approaches to addressing the health needs of its population.

Conferences and workshops serve a number of purposes including providing opportunities for networking, sharing of experiences and exploring areas of mutual concern, and identifying problems and learning from each other how they can be solved. It was in one regional conference on public/private sector partnership held in Namibia in September 1993 that I first met the leadership of the Zambian health reform including Dr. Kamanga, the Permanent Secretary. I was encouraged by what I heard from the Zambian delegation to that conference and followed up with a request to carry out a research on the size, scope and distribution of the private health sector in Zambia. My request was kindly and warmly accepted by the Ministry of Health and by the USAID Mission. Honorable Minister, I would like to thank you and your colleagues for the opportunity you gave us to work with you.

I belong to an office within the Africa Bureau that carries out research and analysis and dissemination of information on key policy and program issues in a wide range of development topics. Private health sector development is one of the key topics our office focuses on. Our approach to selection of topics and identification of key decision issues relies heavily on consultation with our counterparts, the African decision makers. They are our clients, and it is their needs that we strive to satisfy. Our focus on private health sector in general and

private providers in particular was a result of consultations we had with our African counterparts first in Dakar, Senegal in the Spring of 1993 and later in Washington in the Fall of 1993.

Economists classify health financing/economics issues into three broad categories: demand, supply, and financing. Demand is no longer an issue. There exists a fair amount of information that shows that demand for modern health services, public or private, exists and is growing as a result of population increase, urbanization, increase in income, and changes in the epidemiological profile. There is also a fair amount of literature on financing, public as well as private. What is less explored and less known is the size, scope, and distribution of private health care provision. To address this problem our office sponsored four country case studies. The first was Zambia. The others were Kenya, Senegal, and Tanzania. These studies were followed by a regional conference held in Nairobi, Kenya in December 1994. Fourteen African countries were represented. Mr. Musowe, Dr. Nyaywa, Dr. Banda, and Dr. Mwanza participated in this conference. The conference dealt with a number of issues in private provision including size and scope of the sector, private provision of public health services, public/private sector linkages, and constraints on private sector development. Similarities in experience and the constraints faced were astounding. The idea of holding a national conference in Zambia was born at that meeting.

Mr. Chairman, and Honorable Minister, I would like to urge my fellow participants to stay focussed on the issues of health reforms in Zambia and the role of public/private sector partnership in the reforms. While there are two source of provision -- public and non-governmental, there is only one health system -- the Zambian health system. This system is facing a relentlessly growing challenge. The challenge is an incessantly growing demand for more and better care. To successfully tackle this challenge it is imperative that we mobilize all our resources, public and private, and employ them as efficiently as possible. To do so we need to assess the size and scope of each sector, understand the limitations and strengths of all our resources, identify causes for the limitations, and propose solutions that we can carry out collaboratively. This is the central objective of this conference.

Mr. Chairman, allow me to express my appreciation to the Honorable Minister for his leadership in the conception and implementation of health reforms in Zambia, allow me also to thank you Mr. Chairman for your support to public/private sector partnership which most likely pre-dates my interest in this subject, to Mr. Musowe, Dr. Nyaywa, Ms. Mundia, Mr. Sinonge and Mr. Chindele who worked with us very closely in organizing this conference. I would like to mention Dr.

Mannasseh Phiri who did a marvelous job of coordinating the public relations aspect of this conference. Unfortunately, Dr. Phiri is unable to join us today.

Mr. Thomas, allow me to thank you and your colleagues in your Mission, Mr. Hartenberger, Dr. Weirsmas, Mr. Straley, and Mrs. Siwila for their support and cooperation in organizing this conference. I would also like you to know that your Mission was the first in Africa to welcome us do a study of private providers. Such foresight and wisdom is not common place.

I would like to thank my colleagues from the United States, Ms. Purdy and Mr. Nwuke from the Data for Decision Making project, and Mr. Sartorius from Team Technologies. Ms. Purdy is manager of logistics and administrative matters. Mr. Nwuke is our report writer and co-author of the Zambia private sector study. Mr. Sartorius is our facilitator. I would also like to recognize the contributions of other colleagues who are not here today. Drs. Rannan-Eliya and Peter Berman, co-authors of the Zambia study, and Dr. Bob Porter from the BASICS project who was here with us last April and helped prepare the agenda for this conference.

I would also like to thank the numerous members of the Ministry of Health, other branches of the government, and members of the private sector who allowed us to interview them in preparation of this conference and generously shared their ideas with us. Finally, I would like to thank you, my fellow participants, for coming here to work with us.

Thank you Mr. Chairman.

Appendix 4: Opening Speech Entitled “Health Care Reforms: Meeting the Challenge for Partnership” by the Honorable (Dr.) Katele Kalumba, Deputy Minister of Health

**Zambia National Conference, Public-Private Sector Partnership
for Health, Siavonga, Zambia, June 8-11, 1995**

Mr. Chairman

The Acting Director USAID,

His Excellency, The WHO Representative,

Hon. Miyanda,

Distinguished delegates from our National and International Partners.

Ladies and gentlemen

Re: Health Care Reforms: Meeting the Challenge for Partnership

Health care systems around the world, from the U.S. to Khirigistan, from Tunisia to South Africa, are going through a process of reform. Although their situations differ greatly -- in the health status of their populations, the costs of their system, how the system is financed and how equitable it is believed to be -- the motivation for health reform commonly centers around efforts to improve effectiveness, efficiency, and equity. The decision to implement reform of some scale implies that an assessment (formal or informal) of the existing system has indicated that present health status is unacceptable, that the costs of health care (to the government, private sector and individuals) are unsustainable, and/or that certain groups do not have sufficient access to care. It also implies that, given existing resources, the government believes that improvements can be

achieved. In developing countries, although resource constraints for health care may be severe, a commitment to improving the system can have a significant impact on the health of the population.

The Republic of Zambia has undertaken the challenge of comprehensive health care reform. The Ministry of Health has worked with a consortium of international partners to steer into existence a structurally transformed national health care system driven both by cost-effectiveness technologies and value-based total health care quality improvement principles. A convergency of technical approaches to reform has emerged, fostered by the core health reform policy principles of Leadership, Accountability and Partnership (LAP), which have been espoused by Zambia's Ministry of Health.

Mr. Chairman, these reforms are being undertaken amidst very turbulent health reform environment. This environment is evidently, complex. It is characterized as a situation where events beyond the control of a particular sector of government directly affect its operations. The consequences which flow from the actions of individual sectors lead off in ways that become increasingly unpredictable. The nature of rewards and constraints are constantly changing. Government Ministries like other organizations including Non-governmental organizations (NGOs) are being pressed to become highly interdependent yet adversarial in their interrelations as they struggle to influence resource allocation. We are all experiencing our modern turbulent environment as being complex, uncertain, rapidly changing, and beyond the comprehension or control of any one element.

Perhaps as a consequence of the reality of turbulence, Increasingly Mr. Chairman, I am becoming aware of a major contradiction in our health policy administration. The incidence of opposing demands and conflicting pressures that have to be absorbed by the health care system has risen as we draw closer to both local government elections this year and general Presidential and Parliamentary elections next year. The situation has not been helped by the frequency of by-elections both at the municipal and Parliamentary level. This situation requires us to maintain the delicate balance between the needs for popular legitimacy and efficient government. Under these conditions Mr. Chairman, there is a danger, if we do not adjust our leadership styles, that we can be caught up in both a self-paralysing and self-destructive pattern.

Recent disquiet in our national media about cost-sharing schemes and managerial reforms introduced in public health facilities represent two specific problems in Zambia's public policy realities. Politically, it reveals the delicate nature of our political consensus regarding the need for reforming the paternalistic, inefficient, cost-insensitive and ineffective structures of health care that Zambia endured for many years. And strategically, it reflects the technical challenges involved in the political management of the implementation of reform by the Health Ministry itself.

It is true Mr. Chairman, that any changes in health policy require thoughtful and strategic political management. The reason: because policy reform is a profoundly political process. Politics affects the origins, the formulation, and the implementation of health policy, especially when significant changes are involved. Unfortunately, our health care workers are not adequately prepared in their professional education with the skills needed to analyze and strategically manage the socio-political process of health care reform, not just here in Zambia but globally.

From another perspective, reforming a national health care system in a way that would have significant impact on how the sector is managed both in human, infrastructural and financial resource terms, involves the resolution of complex technical elements. Unfortunately, it is sometimes the case that leaders who are charged with the political management of the Health Ministry, are ill-prepared to appreciate and politically advocate for technical considerations in the reform process.

From these two problems, the consequence is either that technically sound health policies are resisted by the public or, politicians peddle, in a politically convenient manner, policies that are technically flawed and end up costing society heavily in terms of its health, money or both. Again, it is important to point out that political ineptness on the part of professionals or the technical incapacity of politicians are not inevitable problems in health sector reform. They can be avoided. Professionals must appreciate political realities including the political calendar so as to put into context, any new policy proposal that a government may suggest. Similarly, politicians must learn to listen to technical advice and to allow technical teams to evaluate policy proposals before they are announced to the public.

The politics of current affairs, driven as they are by an aversiveness to serious thinking and a preoccupation with the politically convenient transforms health and health care as one of the many political favors to be exchanged between political patrons and clients.

Health reforms have been designed to:

- effect the reallocation of resources which will be required to ensure that every Zambian receives at least a minimum package of cost-effective health care
- improve the infrastructure at the most critical levels of the system, namely the health center

- build the capacity of staff to effectively deliver essential health care services
- decentralize authorities and financial control so that those with the knowledge of the local situation will be able to promptly apply locally appropriate responses (decentralized budgets to Districts through the grant system which was tested for 2 years has been achieved, yet erratic political appointment of Boards and delayed legislation continues to hinder effectiveness)
- build the capacity of staff at the district and province so that they can plan, administer and evaluate effective solutions to local priorities (Improved service Plans achieved in 1994, only two out of 61 District failed to meet Plan and audit criteria of MOH and Donors);
- discover ways which will enhance community participation in decision making; and (Area Health Boards and Community Neighborhood Health Watch being implemented in activities such as Cholera control);
- tap into the resources of the private sector in order to complement public sector financing of the production of staff, health sector research, and most of all the provision of services. (Opportunities for franchising being discussed with private sector practitioners in a Partnership for Health Campaign)

It appears to me, Mr. Chairman, that Health Reforms are the answers to many public concerns that have attracted the attention of some of public commentators, and not the problems.

People want more and better quality health care. It means we guarantee both good services and good budgets. In attempting to answer the question: "How can we deliver equitable, cost-effective, quality health care essential to our people?", Zambia's Health Reforms are designed to cater to both political legitimacy and efficiency problems .

This is the practical problematic of health reforms. What we need to answer this question has been clear: Effective Leadership, Accountability and Partnership. When these elements are present at the policy leadership level, Zambian politicians have joined the mass of our people in complimenting the health sector.

Much of the critical remarks regarding our national health reforms in our national media has centered around the question of money and of apparent policy inconsistencies. In their material substance, they have the effect of reducing health reforms to fee paying and specific

political utterances. It is important to address those issues that may divert our attention from the vision.

Against current media criticisms of government health care financing policies, the basic starting point of defense, in my opinion, is that government's approach to health care reform is based upon the need to maintain continuity. The MMD government has not introduced a new policy on medical fees or Hospital Management Boards. It has, however, attempted (and continues to attempt) to provide strong leadership in the delicate process of politically implementing necessary and pre-existing policy measures.

Although government has primary responsibility for overall policy making and strategic planning for the health care delivery system, it is not the only actor in financing health care and allocating health care expenditures. Reviews conducted by various independent consultants in Zambia over the past five years confirm that private out-of-pocket expenditures represent a sizeable per cent of all expenditures on health in Zambia. While the exact magnitude of this contribution is not clear, differing from source to source and influenced by whether, a good conceptual framework was available to take into account the costs of traditional health care, it is generally agreed that government can mobilize private and out-of-pocket resources to stimulate private financing, increase revenues, and alleviate budgetary shortfalls among public providers.

It is a fact, under the 1985 Medical Services Act, the UNIP government not only realized that direct management of our major hospitals by the Ministry of Health was inefficient but that these institutions had to be given enough capacity to raise revenue from users, including prescription charges. Therefore any political critique of this policy must take into account its historical precedents.

The current Hospital Management Boards were legislated for in the 1985 Act and so were user fees! What UNIP was unable to effectively do then, despite its apparently correct understanding of the problems of health sector management, was to have the political capacity to implement its own policies and legislation. We all remember the flip-flopping, and half-hearted attempts at effecting the institutional imperatives of the 1985 Act. A Hospital Management Board was awkwardly set up at UTH and not at other major Hospitals. Medical fees were introduced on and off. The only place where they were consistently implemented in a modest fashion were in some Mission medical facilities.

What we learned over the years was that government policy dilemma did not

either improve the quality of health services or access to them by the poor in this country. In fact, while major urban hospitals began to decline in quality in the early 1980s and worsened by the end of the decade, rural health care had already started to deteriorate by the middle of the 1970s. Hence, in earnest, the flawed primary health care initiatives of 1980 were designed to arrest the decline of rural health care in the same manner that the 1985 Medical Services Act was targeted at major hospitals.

By 1990, it had become increasingly difficult for government health policy makers then to maintain the ideological dissimulation that free health services were going to be sustainable.

Most people recall that from time to time, UNIP politicians were explicitly forbidden to raise cost sharing as a viable policy option in arresting two empirical problems of health care then. The first observable problem was the decline in public finance of health services, in real economic terms by 40 per cent during the 1980s. This affected most acutely, those services often needed by the poor. During this period, primary health care services designed to meet the bulk of health care needs by the majority of Zambians, were being financed through donor support. At the same time, central government revenue was being swallowed up by investments into services provided by three central hospitals of UTH, Ndola and Kitwe.

Government investments into the major hospitals at the expense of district health services did little to improve the quality of services in these hospitals. Who has already forgotten the look of UTH, Ndola and Kitwe just three years ago? The pattern of starving district health services of adequate funding in preference to the big hospitals, is the single biggest social policy tragedy in the political history of health care in Zambia.

As early as 1982, a WHO\UNICEF report decried the impact of government policies in health in this manner: There are no Zambian doctors among the 53 district medical officers and only 2 out of the 9 provincial medical officers are Zambian (one in Lusaka province). The same report describes Lundazi District Hospital in 1982 thus: hospital toilets are continuously blocked; a diesel generator designed to supply energy had been unrepaired for more than two years; cold-chain fridges (where vaccines are stored) had not been working for eight years; and five fridges sent for repair to MSB were never returned. In 1982, Lundazi District Hospital was not far different from Dr. Haslam's 1946 description of Abercon hospital as a "gaol" and Balovale and Fort Rosebery as "museum specimens of bush hospitals".

A Daily Mail editorial comment of July 30, 1987 told us: The thought of walking for miles to a rural hospital which turns out to be no better than a clinic because there is no doctor is pathetic...Yet that is what is happening in many hospitals.

The need to reform the way health services were financed and managed, and within it, resources allocated, had become a policy necessity long before MMD came to power. The half-hearted reforms during the 1980s is testimony to this fact. What this means is that health workers must understand the continuity in this policy issue for them to begin to build dialogue with the community. If the policy is viewed as a politically driven policy without justification in reality, health workers themselves as "political beings" will have difficulty in defending it to the public or to themselves.

It is stated MMD government policy (and again in line with the reality which even the UNIP government appreciated) that every able-bodied Zambian must be encouraged to contribute to the cost of their own health care. However, one of the main policy strategy in current health reforms is to consider cost sharing as an instrument of popular empowerment. A careful balance has to be continuously struck therefore between the goals of revenue enhancement and of popular empowerment. This requires careful technical planning.

What experience suggests is that we know enough about the need to technically consider a variety of issues that increase the chances that user fees are going to serve the intended purpose. In the MMD Policy Framework Paper of 1991, it was clearly stated that user fees must consider issues of quality improvement; of exemptions and of retention of revenue at the collection point. It was stated too that user fees should be introduced at hospitals first before they are generalized to health centers. And further, that Health Boards at the District level must offer the authority necessary to ensure accountability of revenues collected. Zambians will recall that in 1992, the Ministry of Health spent time educating the people on the merits of cost sharing. And in general the public more or less accepted the change when it finally arrived in 1993. However, political turbulence typified by regular parliamentary by-elections has fractured the consensus that had begun to emerge as political parties and politicians sought to define campaign issues. The Ministry of Health has not been particularly sensitive to the political turbulence in terms of fashioning out information strategies designed to counter the periodic spasms in public opinion about user fees, including correcting implementation errors by both policy makers and technical staff. Instead, the public has been left guessing about the intent of government in its strategy of user fees. The exemption systems has been a particular weakness in the practical implementation of user fees. Inadequate

information and poor political advocacy has by and large deprived many access to services under conditions where they were in fact deserving exemption. These are avoidable problems. The strategic role of user fees in the overall health sector finance strategy of the government has not been taken advantage of due to misconceptions at the political level. This has been particularly the case with respect to the process of introducing pre-payment schemes initiated in 1994.

The new frontier of health reform in Zambia, is building our capacity to forge mutually beneficial and complementary links between the government and the private sector. In this area, Mr. Chairman, we can do with more than a little help from our friends.

A central issue in the understanding of health sector reform is that between the terms public and private. On its face value, this may seem to have an obvious response: public is what is owned by the government while private is everything else. The fact is the reality is more complicated than that.

Consider first the term public. There are in many countries, developing and developed, a wide variety of different arrangements of both ownership and operation of health facilities that nonetheless are characterized as public. These include not only ownership by the State, central national government- but also by regional or sub-regional municipal authorities. These may be accountable to either elected public officials or to appointed officials. In addition, beyond level of government, there are considerable differences in the type of supervision exercised by a public authority. Health care institutions can be directly managed, in a hierarchical or bureaucratic framework... as in the pre-1991 British National Service. Alternatively, they can be given substantial entrepreneurial freedom as quasi-independent agencies such as UTH....entities that are publicly capitalised but then relatively speaking, autonomously managed. Managed upon the basis of objectives they are supposed to achieve, managed in a strategic sense by the public authority, rather than managed on a day- to- day basis in terms of operations and inputs. Hence, within the category of public , there a category of quasi-independent agencies which can be called public firms. Within the public sector generally, there are in fact a wide range of different structural options.

The term private is even more imprecise than the term public. First, there is the distinction between for-profit as against non-profit ownership. For profit status indicates that private individuals have put up or borrowed the institutions' equity capital, and, having risked these

funds in the business, expect to keep any accrued earnings. This of course can grow into a public company if it became large enough to issue stock. Not-for-profit, conversely, is an umbrella category that contains a number of different organizational formats. The formal term refers only to ownership of capital: no group of individuals or lenders has contributed risk capital on which they expect to earn a profit. Instead the funds, remaining at the end of the budget year are referred to as "surplus". Definitional problems arise here when we consider the appropriation of these "surplus" by senior executives in terms of salaries and fringe benefits as public choice economists would argue. In practice, not-for-profit can be religious, community, geographical in character, and can run the gamut from amateur to professional in their size of management.

The key question to keep in mind is: do these organizational forms behave as differently as we expect them to?

It is my opinion that one of the pre-conditions to tapping into the potential offered by the private sector will be a clarification of the health sector financing policies and modalities. It is my view that to effective, social policy in any field including health must not work at cross-purposes to macroeconomic realities, particularly, its market logic. Unless principles that support successful macroeconomic policy performance are rationalized with a given social sector's operating logic, that will die or draw down the movement of the engines of change. I see as our major challenge in this new frontier of health reform, a concerted effort to articulate our financing policies that are consistent with our overall macroeconomic realities or imperatives. We need to examine carefully the structure and impact of the general tax revenues used for direct public provision; public insurance contributions used to purchase services from not-for-profit providers; general revenue used to purchase the services of private for-profit providers. We also need to examine user fees paid for private use of public facilities; user fees paid for-not-profit facilities and private insurance payments paid to providers in private practice.

From a managerial stand point we need to examine the accompanying managerial technologies that are suggested by private sector logic. In particular, we need to carefully examine some general assumptions critically. These include: That the private sector is free from administrative and political constraints commonly associated with public bureaucracies. What opportunities exist in investing our efforts in promoting private sector development in terms of improving resource management for efficient and effective health service delivery? Another assumption: Scarce resources will be freed up to

provide services to the poor to the extent that those individuals who are willing and able to pay for health services seek care outside the public sector. Lastly, is the assumption, that the infusion of “market forces” (the notion of public market policies) such as competition and incentives, will lead to improvements in service quality. If these assumptions are correct, how can realize them here in Zambia?

This is a long road, we must continue to travel hopefully through careful and critical thinking about policies.

Appendix 5: Participant List

Zambia National Conference on Public-Private Partnership for Health, June 8-11, 1995, Siavonga, Zambia

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Appendix 6: Conference Objectives and Agenda

Zambia National Conference, Public-Private Sector Partnership for Health, Siavonga, Zambia, June 8-11, 1995

Objectives

1. To Provide a Forum for Government to Express its Commitment in Forging Partnerships with the Private Sector;
2. To Offer Various Components of the Private Sector the Opportunity to Communicate with Government and Express Their Vision for a Harmonious Partnership;
3. To Define the Contractual Relationship Between Government (Purchasers) and Private Sector;
4. To Recommend Appropriate Policy Reform for Maximizing Private Sector (Provider) Participation in the Public Health Agenda;
5. To Identify Critical Steps in the Development of Public/Private Sector Partnership, Develop an Implementation Plan, and Assign Tasks.

Agenda

Thursday, June 8

14:00 - 19:00

Arrivals/Registration

19:45

Dinner

Friday, June 9

8:30 - 9:15

Participant Introductions/Expectations

9:15

Opening Remarks by the Chairman, Dr. Kawaye Kamanga, Permanent Secretary, Ministry of Health

Address by Mission Director, Usaid/Zambia

Address by HHRAA/AFRICA BUREAU Usaid/Washington, DC

Opening Address by the Hon. (Dr.) Katele Kalumba, Deputy Minister of Health.

Break

Presentation: Health Sector Reform/National Health Strategy, Chief Health Planner, MOH; HRIT Team Leader, MOH.

Concepts and Issues in Public/Private Sector Partnership for Health

Lunch

Panel Discussion: **The Private Sector Role**, University Teaching Hospital, Medical Council of Zambia, Traditional Health Practices Association of Zambia, Pharmaceutical Society of Zambia, Zambia Consolidated Copper Mines

Break

15:15 - 17:00

Group Discussions

17:00 - 17:15

Closing Round

Saturday, June 10

A.M.

Yesterday in Review

Working Group Discussions

1. Health Sector Reform & Implementations for Private Sector. Discussant, Team Leader, HRIT
2. Role of Private Sector in New Reform. Discussant Chief Health Planner, MOH
3. How Would Consumers Be Affected? Discussants: Members of Parliament, NGOCC

Reports to Plenary and Discussion

Constraints to Private Sector Participation (Visualization)

Small Working Groups

Brain Storming Process Listing Constraints

Post Constraints on Wall under 6 Headings:

Political/Legislative;

Institutional;

Financial and Economic;

Human Resource;

Commodities/Medical Supplies;

Social/Cultural and Other.

Lunch

P.M

Trust Building Exercise

Working Groups on Constraints identified

Removing Political and Economic Constraints;

Strengthening Public/Private Linkages at National and District Levels;

Removing Constraints to Human Resources;

Removing Constraints to Commodities, Medical Supplies
And Pharmaceuticals;

Break

Report to Plenary

Sunday, June 11

Yesterday in Review

Presentation to Plenary of the Working Group How Would Consumers Be Affected?

Presentation on Franchising

Working Group Presentations

Instructions on Setting up Task Force

Closing Remarks: Three Private Sector Participants and the Member of Parliament

Conference Evaluation